Fever ≥ 3 days* (temp ≥ 38.0 or subjective temp)†
AND
Two or more organ involvement (cardiac, renal, respiratory, GI, dermatologic, neurologic)
OR
Fever ≥ 4 days and no obvious source

*Strongly recommend follow up within 24 hours for patients with 2 days of fever and any symptoms listed

JHCC Peds ED MIS-C Guidelines*
May 29, 2020
*These are soft guidelines based on limited evidence. Tool is a guide for evaluation and subject to change as more evidence becomes available. It does not replace clinical judgement or decision making.

Fever ≥ 3 days* (temp ≥ 38.0 or subjective temp)†
AND
Two or more organ involvement (cardiac, renal, respiratory, GI, dermatologic, neurologic)
OR
Fever ≥ 4 days and no obvious source

Consider admission if but not necessary or limited to:
- Elevated
  - CRP > 3, ESR
- Cardiac abnormalities (Troponin, Pro-BNP, echo)
- Leukopenia and/or thrombocytopenia
- Meets lab criteria for atypical Kawasaki
- Persistent abdominal pain with findings of bowel edema or mesenteric adenitis on imaging
- Meeting pediatric SIRS criteria following antipyresis
- Other usual reasons for admission

Unstable
OR
Cardiac abnormalities

Stable
Floor

Labs
CRP
CMP
Ferritin
Troponin
Pro-BNP
CBC/ESR
D-dimer
Blood Cx
UA

COVID
- NAT NP swab
- COVID IgG/IgA
- +COVID contact in past 4 wks

Imaging
- EKG
- Chest x-ray
- If respiratory complaints
- Echocardiogram
- If cardiac findings or ill consult
- Cardiology for ED or inpatient echo
- Abdominal US or CT
- If GI complaints
- Add pictures of rashes to EPIC chart

Consider work-up if Kawasaki symptoms without fever

Presentation
Systemic
Fever
Myalgias
Lethargy
Loss of smell or taste

Cardiac/Circulation
Tachycardia
Hypotension
Hypo/hyperperfusion
Syncope

Gastrointestinal
Abdominal pain
(Can mimic surgical abdomen)
Nausea/vomiting
Diarrhea
Loss of appetite

Neurologic
Headache
Altered mental status
Meningismus
Focal deficits
Seizure

Respiratory
Cough
Sore throat
Respiratory distress
Chest pain

Mucocutaneous†
Lymphadenopathy
Rash (Please add pictures of rashes to EPIC chart)
Lip swelling/cracking/erythema, strawberry tongue
Conjunctivitis
Swollen hands/feet
Erythematous/violaceous changes of toes

CRP
CMP
Ferritin
Troponin
Pro-BNP
CBC/ESR
D-dimer
Blood Cx
UA

COVID NAT NP swab
COVID IgG/IgA
+COVID contact in past 4 wks

EKG
Chest x-ray
If respiratory complaints
Echocardiogram
If cardiac findings or ill consult
Cardiology for ED or inpatient echo
Abdominal US or CT
If GI complaints
Add pictures of rashes to EPIC chart

Discharge with PCP follow-up in 24 hours. Consider obs period in ED to monitor vital sign changes. (If no PCP, consider return to ED in 24hrs if fever persists)

Workup may be completed simultaneously or sequentially
- Red: recommended labs if highly suspicious for MIS-C
- Bold labs are sent in a single Gold Top Tube; Can send together
- Echo order: write in order: "Concern for MIS-C" + COVID pending or result.
Consider PICU admission

- Signs of shock, respiratory, or neurologic decompensation
- Persistent tachycardia
- Abnormal cardiac markers or echocardiogram (Per Cardiology, echo will NOT be used to determine floor vs PICU placement)
- Frequent abdominal exams or neuro exams
- If not clear disposition, discuss with PICU for shared decision making

Other involved specialists available for consults

- Cardiology
- Rheumatology
- Infectious Disease
- Gastroenterology
- General Pediatric Surgery

<table>
<thead>
<tr>
<th>Initial Resuscitation Guidelines</th>
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<tbody>
<tr>
<td><strong>Fluid resuscitation</strong></td>
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<tr>
<td>10 cc/kg aliquots of NS if evidence of dehydration/shock; carefully assess response/tolerance of fluid (hemodynamic response, lung exam/liver edge; POCUS exam of IVC if available) as boluses are administered</td>
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<tr>
<th><strong>Vasoactives</strong></th>
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<tr>
<td>Shock with poor perfusion:</td>
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<tr>
<td>epinephrine, 0.02-0.05 mcg/kg/min, titrate to effect; use with caution in patients with extreme tachycardia</td>
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<tr>
<td>Consider addition of milrinone, 0.25 – 0.5 mcg/kg/min if oxygen delivery remains inadequate</td>
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<th><strong>Hydrocortisone</strong></th>
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<td>If unresponsive to vasoactives, consider stress dose hydrocortisone, 25 – 50 mg/m²/dose q6h; send spot cortisol or complete ACTH stim test prior to first dose if possible</td>
</tr>
</tbody>
</table>


JH HEIC guidance on clearing MISC from inpatient negative pressure rooms: MIS-C in Pediatrics- Infection Control Considerations